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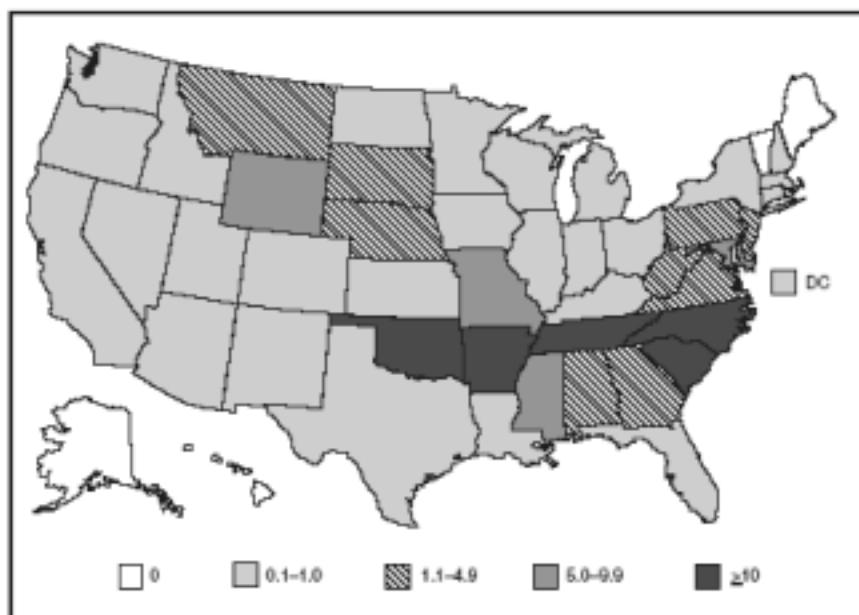
### Rocky Mountain Spotted Fever in South Dakota

By Lon Kightlinger, MSPH, PhD, State Epidemiologist, Department of Health

Rocky Mountain spotted fever (RMSF) is a tick-borne rickettsial disease caused by *Rickettsia rickettsii*. Nationally, cases of RMSF have increased nearly four-fold since 2000. Although RMSF cases have been reported from across the United States, more than half of the cases are from southeastern states of North Carolina, South Carolina, Tennessee, Arkansas, Oklahoma, Mississippi and Alabama.

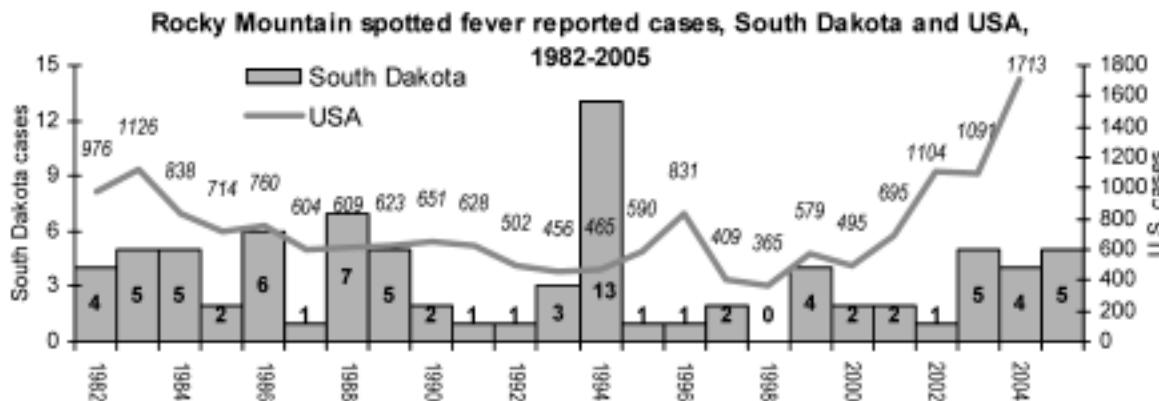
Average reported annual incidence\* of Rocky Mountain spotted fever, by state – United States, 1997 – 2002. (Source: CDC)

Cases of RMSF are reported in South Dakota each year. Since 1993 there have been 43 cases of RMSF reported from 23 counties across the state. The incidence of RMSF cases is three times higher West River than East River. Pennington County has had the most RMSF cases, 9, since 1993.



\* Per 1,000,000 persons per year.

**Primary vectors:** American dog tick (*Dermacentor variabilis*) is found throughout South Dakota, and the Rocky Mountain wood tick (*Dermacentor andersoni*) is found in higher elevations of western South Dakota. The *Rickettsia* is maintained in wild animals and tick populations.



**Prevention:** Avoiding tick bites and promptly removing attached ticks. No licensed vaccine available.

**Season:** Spring – summer.

**Incubation period:** 2-14 days

**Clinical features:** Fever, headache, malaise and sometimes gastrointestinal symptoms. Rash, usually starts peripherally and moves centrally; might involve soles and palms; progresses from maculopapular to petechial. Maculopapular rash approximately 2-4 days after fever onset in 50% - 80% of adults (>90% in children).



**Case fatality rate:** 5% - 10%.

**Common laboratory abnormalities:** Thrombocytopenia, mild hyponatremia, mildly elevated hepatic transaminase levels.

#### Confirmatory laboratory diagnosis:

- Serological evidence of a significant change in serum antibody titer reactive with *Rickettsia rickettsii* antigens between paired serum specimens, as measured by a standardized assay.
- Demonstration of *R. rickettsii* antigen in a clinical specimen by immunohistochemical methods.
- Detection of *R. rickettsii* DNA in a clinical specimen by the polymerase chain reaction (PCR assay).
- Isolation of *R. rickettsii* from a clinical specimen in cell culture.

For confirmed cases, a significant change in titer must be determined by the testing laboratory; examples of commonly used measures of significant change include, but are not limited to, a 4-fold or greater change in antibody titer as determined by indirect immunofluorescent antibody (IFA) assay or an equivalent change in optical density measured by enzyme-linked immunosorbent assay (EIA or ELISA). Patients usually do not have diagnostic serum antibody levels during the first week of illness; therefore, an inability to detect antibodies (IgG or IgM) in

acute-phase serum does not exclude RMSF. Health-care providers should not delay treatment while waiting for a diagnosis; rather, they should empirically provide treatment if they suspect RMSF.

### **Resources**

- CDC. Diagnosis and management of tickborne rickettsial diseases: Rocky Mountain spotted fever, ehrlichioses, and anaplasmosis — United States: a practical guide for physicians and other health-care and public health professionals. MMWR 2006; 55/RR-4  
[www.cdc.gov/mmwr/preview/mmwrhtml/rr5504a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5504a1.htm)
- SD State University. Ticks in South Dakota: [http://plantsci.sdstate.edu/ent/entpubs/ticks\\_sd.htm](http://plantsci.sdstate.edu/ent/entpubs/ticks_sd.htm)
- CDC RMSF website: [www.cdc.gov/ncidod/dvrd/rmsf/index.htm](http://www.cdc.gov/ncidod/dvrd/rmsf/index.htm)

### **South Dakota Cancer Registry achieves gold standard award**

*By Mynna Boodhoo Kightlinger, MSPH, South Dakota Cancer Registry Coordinator*

The South Dakota Department of Health's cancer registry, the South Dakota Cancer Registry (SDCR), has received the Gold Standard Certification award from the North American Association of Central Cancer Registries (NAACCR) for cancer incidence data collection in 2003.

The NAACCR has established gold- and silver-standard criteria to recognize population-based cancer registries that achieve excellence in the following areas: completeness of information, data accuracy and timeliness of data submissions.

This year 73 population-based cancer registries submitted their 2003 incidence data for evaluation and confidential feedback as part of the NAACCR Registry Certification process. There are 76 NAACCR member registries in North America that are eligible to submit data files for the registry certification program.

There are two primary reasons for evaluating central cancer registry incidence data.

1. To recognize population based cancer registries that have achieved excellence in the areas of completeness of case ascertainment, quality of the data, and timeliness in producing cancer incidence data.
2. To provide confidential feedback which individual registries can use to identify current and future resources and training needs.

This is the first year that the SDCR has been certified since its establishment as a statewide, population-based registry in January, 2001. The 2000-2003 data is published in *Cancer in North America* (CINA) 1999-2003, which can be accessed for incidence 2000-2003 in Volume 1 and Mortality 1999-2003 in Volume 2.

[www.naaccr.org/index.asp?Col\\_SectionKey=11&Col\\_ContentID=50](http://www.naaccr.org/index.asp?Col_SectionKey=11&Col_ContentID=50)

The SDCR is an active surveillance system that is the foundation for cancer control and prevention activities. It provides information on the cancer burden in South Dakota to programs that target cancer control and prevention as well as provides data for research related to cancer-control activities in the state. Most of all, it functions to evaluate any potential cancer clustering and to respond to citizen concerns about cancer in the areas where they live.

The 2000-2003 data includes cancer cases submitted to the central registry by South Dakota's seven hospitals that are approved by the Commission on Cancer, all pathology laboratories in the state and the Veterans Affairs hospitals. In addition, the SDCR has been collecting cases from other South Dakota health care facilities and providers, and from data sharing agreements with other states on a voluntary basis. The central registry edits, consolidates and resolves duplicates; links the incidence database with vital statistics to pick up cancers that are diagnosed at death; and links the database with the Indian Health Services system in Albuquerque to pick up and correct any racial misclassification of American Indians.

At the same time that the SDCR has achieved certification, it has also achieved the high quality standards for inclusion in the 2003 United States Cancer Statistics (USCS). That report will be published in November 2006 and will cover over 93 % of the U.S. population.

On July 1, 2006, cancer reporting becomes mandatory in South Dakota for any hospital, physician, physician assistant, nurse practitioner, nurse midwife, pathology laboratory, or free-standing radiology center that detects, diagnoses, or treats a cancer case in South Dakota.

**South Dakota Cancer Registry**  
**NAACCR Certification on Quality, Completeness & Timeliness of 2003 Data:**  
**Summary of Certification Measures**

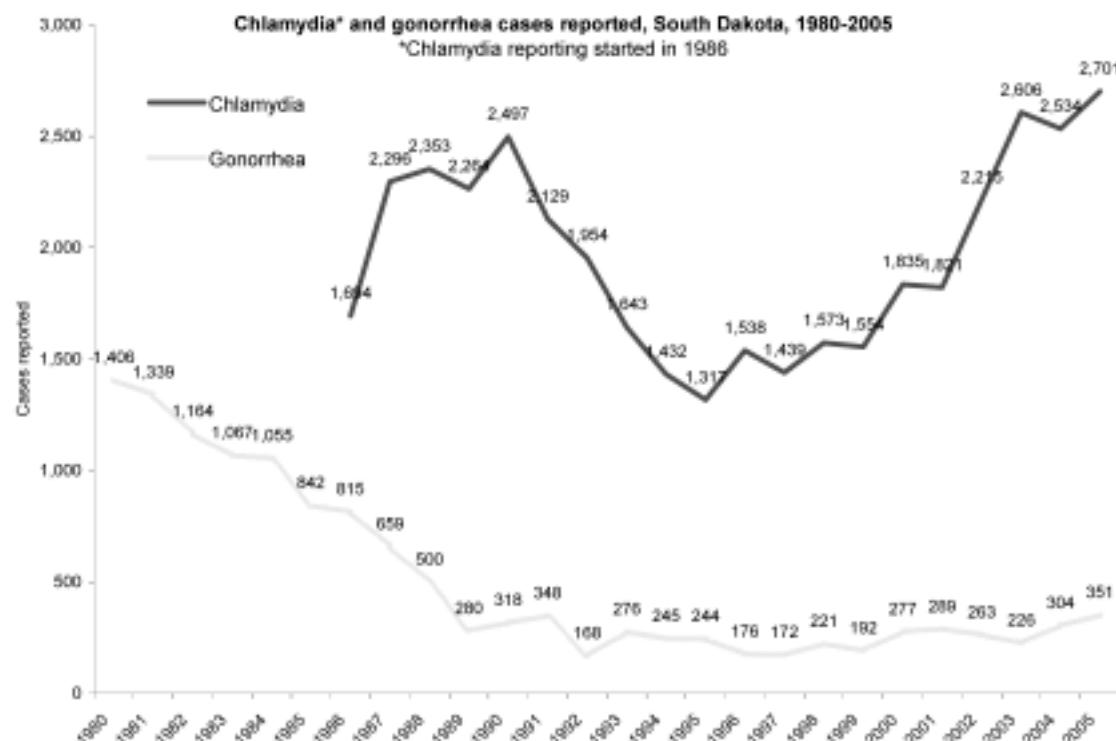
Registry Element	Gold	Silver	Actual	Measuremen t	Standard Achieve d
	Standard	Standard	Measure	Error Allowed	
1. Completeness of case ascertainment	95%	90%	96%	1.0%	Gold
2. Completeness of information recorded					
Missing / unknown "age at diagnosis"	≤2%	≤3%	0.0%	-0.4%	Gold
Missing / unknown "sex"	≤2%	≤3%	0.0%	-0.4%	Gold
Missing / unknown "race"	≤3%	≤5%	0.6%	-0.4%	Gold
Missing / unknown "State & county"	≤2%	≤3%	1.6%	-0.4%	Gold
3. Death certificate only (DCO)cases	≤3%	≤5%	2.9%	-0.4%	Gold
4. Duplicate primary cases	≤ 1 per 1,000	≤ 2 per 1,000	0.5 per 1,000	-0.40%	Gold
5. Passing EDITS	100%	97%	100.00%	Not applicable	Gold
6. Timeliness	Data submitted within 23 months of close of accession year				Gold
	<b>Certification Status</b>				<b>GOLD</b>

The South Dakota Department of Health acknowledges the cooperation and efforts that hospitals, providers and pathology laboratories statewide have made in order for the state to achieve national standards and certification. In particular, the SDCR acknowledges the crucial role played by the 12 hospital certified tumor registrars (CTR) in abstracting high quality cancer data for submission to the central registry and the role of the central registry CTR's in quality assurance activities to achieve national standards.

## Chlamydia and gonorrhea in South Dakota

Reported by Lon Kightlinger, MSPH, PhD, State Epidemiologist, Department of Health  
Dave Morgan, STD Program Coordinator, Department of Health  
Bonnie Jameson, Disease Prevention Administrator, Department of Health

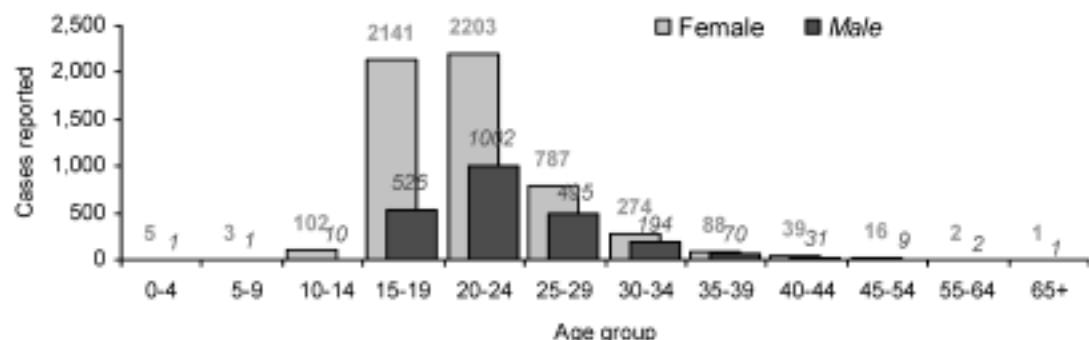
Chlamydia and gonorrhea are the most commonly reported diseases in South Dakota. In 2005, 2,701 cases of chlamydia were reported, the highest since reporting started, and 351 cases of gonorrhea cases were reported, the most since 1988. In 2004 South Dakota had the seventeenth highest chlamydia rate and the forty-first highest gonorrhea rate in the United States.



Chlamydia is a bacterial disease caused by *Chlamydia trachomatis*. Although symptoms are often mild or absent, chlamydia infection can cause serious complications such as ectopic pregnancy or infertility in women. In men chlamydia infection may cause epididymitis and urethral discharge. Chlamydia infection puts people at higher risk of contracting and transmitting HIV.

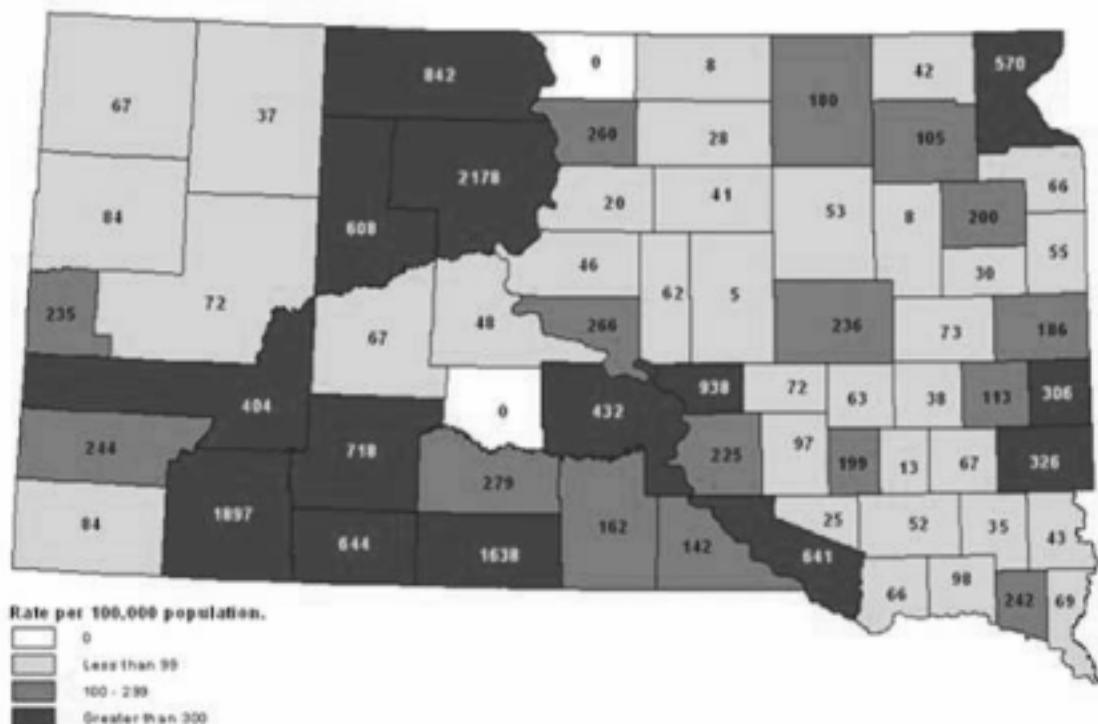
Since 1995 the number of chlamydia cases reported in South Dakota has doubled. Although this increase is partially explained by better clinical screening programs and more sensitive laboratory technologies, the upward trend is real and concerning. Chlamydia cases over the past 6 years, since 2000, were 70% female patients and 30% male; 48% of cases were white race, 47% American Indian and 5% were from other race groups. Females in the 15 – 24 year age group were at highest risk.

## Chlamydia cases reported by gender and age, South Dakota 2000-2005.



In 2005 South Dakota reported 2,701 chlamydia cases, which is a rate of 350 cases per 100,000 population. During the 6 years since 2000 all but two South Dakota counties have reported chlamydia cases. Ninety percent of cases occurred in 21 counties. The map below shows that 14 counties had average annual rates of greater than 300 chlamydia cases per 100,000 population.

### Chlamydia rates by county, South Dakota, 2000 – 2005 (average annual cases per 100,000 population)

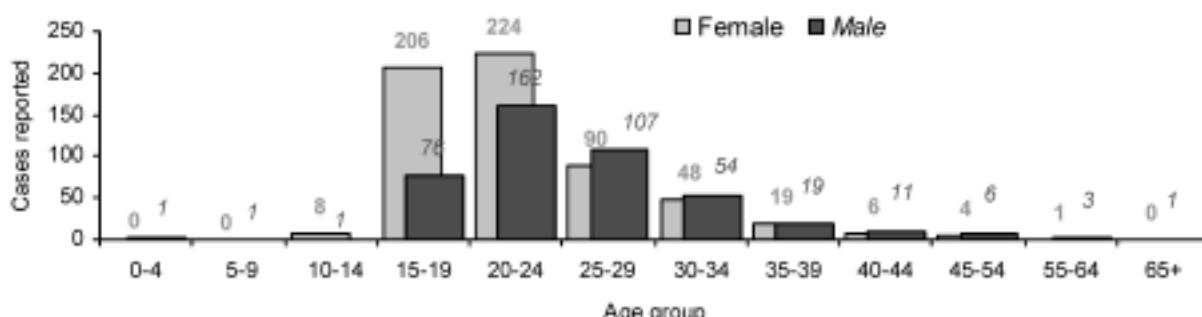


Gonorrhea is a bacterial disease caused by *Neisseria gonorrhoeae* infections of the female cervix, uterus and fallopian tubes, and male and female urethra. The bacterium can also infect the mouth, throat, eyes and anus, and may spread to the blood or joints.

Classic gonorrhea symptoms in women include a burning during urination and increased vaginal discharge. Although gonorrhea infections in women are sometimes asymptomatic or mild, severe and permanent complications may result. Untreated infections can lead to chronic pelvic pain, internal abscesses, damaged fallopian tubes, infertility or ectopic pregnancy. In men

gonorrhea is sometimes asymptomatic, but often causes burning while urinating, or a whitish-green urethral discharge. In men epididymitis may cause infertility. Symptoms appear 2-5 days after infection, but can take as long as 30 days to develop. Gonorrhea infection increases the risk of contracting and transmitting HIV.

#### Gonorrhea cases reported by gender and age, South Dakota 2000-2005.



Over the past 25 years the number of gonorrhea cases in South Dakota has decreased dramatically from over 1,000 cases per year in the early 1980's to less than 200 cases in the late 1990's. Since 2000, however, gonorrhea has been increasing. Over the past 6 years 58% of reported cases were female and 42% male; 58% of cases were American Indian, 29% white, and 13% were from other race groups. Females 15-24 years old were at highest risk.

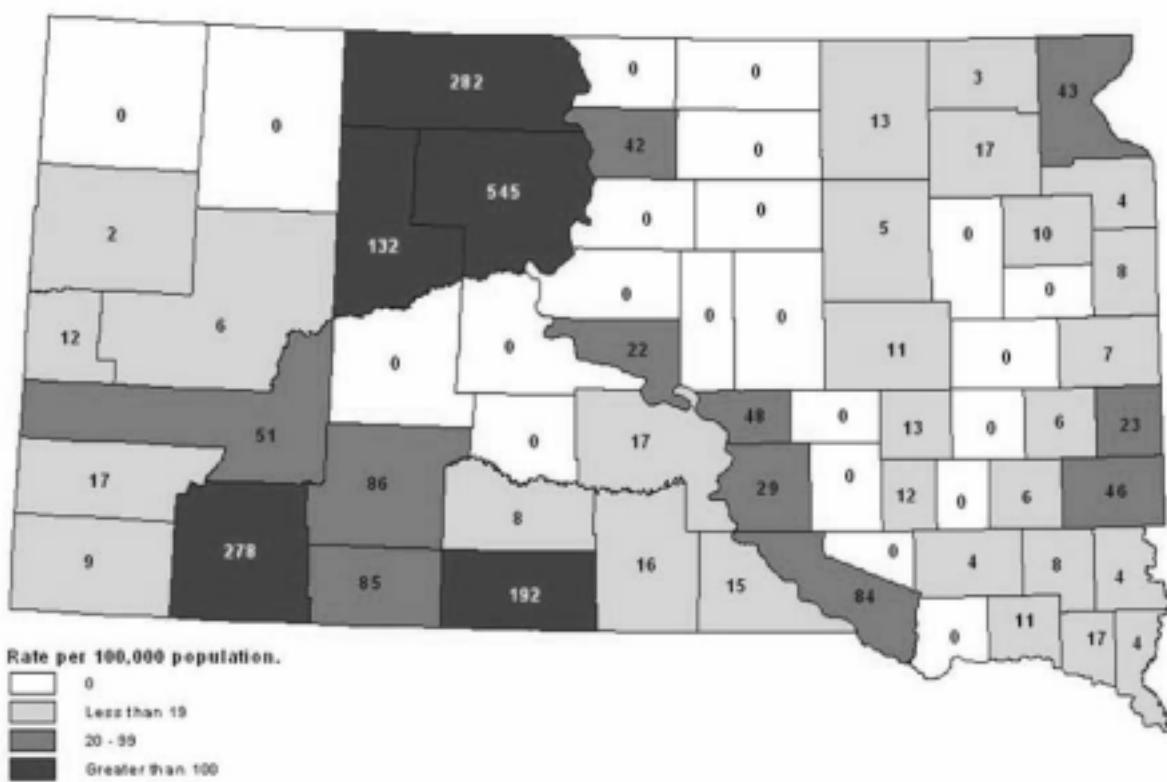
In 2005 South Dakota reported 351 cases of gonorrhea, which is a rate of 46 cases per 100,000 population. During the 6 years since 2000, two-thirds of South Dakota counties have reported cases of gonorrhea with 90% of cases coming from 15 counties. The map below shows that 5 counties had average annual rates of greater than 100 cases per 100,000 population.

**Prevention.** The best way to avoid chlamydia and gonorrhea is to abstain from sexual contact, or to be in a long-term mutually monogamous relationship with a partner who has been tested and is uninfected. Latex male condoms, when used consistently and correctly, can reduce the risk of transmission.

Chlamydia screening is recommended annually for all sexually active women 25 years of age and younger. An annual screening test also is recommended for older women with risk factors for chlamydia (a new sex partner or multiple sex partners). All pregnant women should be screened for chlamydia.

Symptoms such as pain during urination, discharge, or unusual sore or rash should be a signal to stop having sex and to consult a health care provider immediately. If a person has been treated for chlamydia or gonorrhea, all recent sex partners should be notified so they can seek treatment. This reduces the risk of sex partners developing serious complications and reduces the patient's risk of re-infection. The patient and all their sex partners must avoid sex until their treatment has been completed.

## Gonorrhea rates by county, South Dakota, 2000 – 2005 (average annual cases per 100,000 population)



### Resources:

- South Dakota Department of Health [www.state.sd.us/doh/STD/](http://www.state.sd.us/doh/STD/)
- Centers for Disease Control and Prevention: [www.cdc.gov/std](http://www.cdc.gov/std)
- Treatment guidelines: [www.cdc.gov/std/treatment/](http://www.cdc.gov/std/treatment/)
- For testing and counseling for sexually transmitted diseases and HIV/AIDS, contact one of the following Department of Health sites or call 1-800-592-1861
  - Aberdeen (605) 626-2373 or toll free 1-866-805-1007
  - Dupree 605-365-5164 or toll free 1-866-778-5157
  - Pierre (605) 773-5348 or toll free 1-866-229-4927
  - Rapid City (605) 394-2289 or toll free 1-866-474-8221
  - Sioux Falls (605) 367-5363 or toll free 1-866-315-9214
  - Watertown (605) 882-5096 or toll free 1-866-817-4090

### Adult immunization schedule

The current outbreak of mumps is a good reminder of the importance of making sure immunizations are kept up to date for children and adults alike.

The Department of Health encourages all adults to check the schedule of recommended immunizations from the Advisory Committee on Immunization Practice to make sure they are up to date. The schedule can be found on the web at <http://www.cdc.gov/nip/> and is also reprinted in this issue.

For more information about immunizations, see the Department of Health's web site at <http://www.state.sd.us/doh/Immunize/> or call the Immunization Program at 605-773-5323.

# Recommended Adult Immunization Schedule, by Vaccine and Age Group

## UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

Vaccine ▼	Age group ►	19–49 years	50–64 years	≥ 65 years
Tetanus, diphtheria (Td) <sup>1*</sup>			1-dose booster every 10 yrs	
Measles, mumps, rubella (MMR) <sup>2*</sup>		1 or 2 doses	1 dose	
Varicella <sup>3*</sup>		2 doses (0, 4–8 wks)	2 doses (0, 4–8 wks)	
Influenza <sup>4*</sup>		1 dose annually	1 dose annually	
Pneumococcal (polysaccharide) <sup>5,6</sup>		1–2 doses	1 dose	
Hepatitis A <sup>7*</sup>			2 doses (0, 6–12 mos, or 0, 6–18 mos)	
Hepatitis B <sup>8*</sup>			3 doses (0, 1–2, 4–6 mos)	
Meningococcal <sup>9</sup>			1 or more doses	

NOTE: These recommendations must be read along with the footnotes.

\*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection):

■ Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

This schedule indicates the recommended age groups and medical indications for routine administration of currently licensed vaccines for persons aged ≥ 19 years. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations, consult the manufacturers' package inserts and the complete statements from the ACIP ([www.cdc.gov/nip/acip-list.htm](http://www.cdc.gov/nip/acip-list.htm)). Report all clinically significant postvaccination reactions to the Vaccine Adverse Event Reporting System (VAERS). Reporting forms and instructions on filing a VAERS report are available by telephone, 800-822-7967, or from the VAERS website at [www.vaers.hhs.gov](http://www.vaers.hhs.gov). Information on how to file a Vaccine Injury Compensation Program claim is available at [www.hrsa.gov/vicp](http://www.hrsa.gov/vicp) or by telephone, 800-338-2382. To file a claim for vaccine injury, contact the U.S. Court of Federal Claims, 717 Madison Place, N.W., Washington D.C. 20005, telephone 202-357-5400. Additional information about the vaccines listed above and contraindications for vaccination is also available at [www.cdc.gov/nip](http://www.cdc.gov/nip) or from the CDC-INFO Contact Center at 800-CDC-INFO (232-4636) in English and Spanish, 24 hours a day, 7 days a week.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION



# Recommended Adult Immunization Schedule, by Vaccine and Medical and Other Indications

## UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

Indication ▶	Pregnancy	Congenital immunodeficiencies: leukemia; <sup>3</sup> lymphoma; <sup>3</sup> generalized malignancy; <sup>3</sup> carbrosplenic fluid leaks; therapy with alkylating agents, antimetabolites, radiation, or high- dose, long-term corticosteroids	Diabetes; <sup>4</sup> heart disease; chronic pulmonary disease; chronic liver disease; including chronic alcoholism	Aplasia; <sup>5</sup> including effective splenectomy and terminal complement component deficiencies)	Kidney failure, end-stage renal disease; recipients of hemodialysis or clothing factor concentrates	Human immunodeficiency virus (HIV) infection; <sup>6</sup> AIDS	Healthcare workers
Vaccine ▼							
Tetanus, diphtheria (Td) <sup>1*</sup>				1-dose booster every 10 yrs			
Measles, mumps, rubella (MMR) <sup>2*</sup>					1 or 2 doses		
Varicella <sup>3*</sup>				2 doses (0, 4–8 wks)			
Influenza <sup>4+</sup>		1 dose annually			1 dose annually		2 doses
Pneumococcal (polysaccharide) <sup>5,6</sup>	1–2 doses			1–2 doses			1–2 doses
Hepatitis A <sup>7+</sup>				2 doses (0, 6–12 mos, or 0, 6–18 mos)			
Hepatitis B <sup>8*</sup>				3 doses (0, 1–2, 4–6 mos)		3 doses (0, 1–2, 4–6 mos)	
Meningococcal <sup>9</sup>			1 dose		1 dose	1 dose	

NOTE: These recommendations must be read along with the footnotes.  
 \*Covered by the Vaccine Injury Compensation Program.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection)

Recommended if some other risk factor is present (e.g., based on medical, occupational, lifestyle, or other indications)

Contraindicated

Approved by the Advisory Committee on Immunization Practices (ACIP),  
 the American College of Obstetricians and Gynecologists (ACOG), and the American Academy of Family Physicians (AAFP)

## Footnotes

## Recommended Adult Immunization Schedule, UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

**1. Tetanus and Diphtheria (Td) vaccination.** Adults with uncertain histories of a complete primary vaccination series with diphtheria and tetanus toxoid-containing vaccines should receive a primary series using combined Td toxoid. A primary series for adults is 3 doses; administer the first 2 doses at least 4 weeks apart and the third dose 6–12 months after the second. Administer 1 dose if the person received the primary series and if the last vaccination was received  $\geq$  10 years previously. Consult ACIP statement for recommendations for administering Td as prophylaxis in wound management ([www.cdc.gov/mmwr/preslev/mmwrhtml/00041615.htm](http://www.cdc.gov/mmwr/preslev/mmwrhtml/00041615.htm)). The American College of Physicians Task Force on Adult Immunization supports a second option for Td use in adults: a single Td booster at age 50 years for persons who have completed the full pediatric series, including the teenage/young adult booster. A newly licensed tetanus-diphtheria-acellular pertussis vaccine is available for adults. ACIP recommendations for its use will be published.

**2. Measles, Mumps, Rubella (MMR) vaccination.** Measles component: adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive  $\geq$  1 dose of MMR unless they have a medical contraindication, documentation of  $\geq$  1 dose, history of measles based on healthcare provider diagnosis, or laboratory evidence of immunity. A second dose of MMR is recommended for adults who 1) were recently exposed to measles or in an outbreak setting, 2) were previously vaccinated with killed measles vaccine, 3) were vaccinated with an unknown type of measles vaccine during 1963–1967, 4) are students in postsecondary educational institutions, 5) work in a healthcare facility, or 6) plan to travel internationally. Withhold MMR or other measles-containing vaccines from HIV-infected persons with severe immunosuppression. Mumps component: 1 dose of MMR vaccine should be adequate for protection for those born during or after 1957 who lack a history of mumps based on healthcare provider diagnosis or who lack laboratory evidence of immunity. Rubella component: administer 1 dose of MMR vaccine to women whose rubella vaccination history is unreliable or who lack laboratory evidence of immunity. For women of childbearing age, regardless of birth year, routinely determine rubella immunity and counsel women regarding congenital rubella syndrome. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Women who do not have evidence of immunity should receive MMR vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility.

**3. Varicella vaccination.** Varicella vaccination is recommended for all adults without evidence of immunity to varicella. Special consideration should be given to those who 1) have close contact with persons at high risk for severe disease (healthcare workers and family contacts of immunocompromised persons); or 2) are at high risk for exposure or transmission (e.g., teachers of young children; child care employees; residents and staff members of institutional settings, including correctional institutions; college students; military personnel; adolescents and adults living in households with children; nonpregnant women of childbearing age; and international travelers). Evidence of immunity to varicella in adults includes any of the following: 1) documented age-appropriate varicella vaccination (i.e., receipt of 1 dose before age 13 years or receipt of 2 doses [administered at least 4 weeks apart] after age 13 years); 2) born in the United States before 1966; 3) history of varicella disease based on healthcare provider diagnosis or self- or parental report of typical varicella disease for non-U.S.-born persons born before 1966 and all persons born during 1966–1997 (for a patient reporting a history of an atypical, mild case, healthcare providers should seek either an epidemiologic link with a typical varicella case or evidence of laboratory confirmation, if it was performed at the time of acute disease); 4) history of herpes zoster based on healthcare provider diagnosis; or 5) laboratory evidence of immunity. Do not vaccinate women who are pregnant or might become pregnant within 4 weeks of receiving the vaccine. Assess pregnant women for evidence of varicella immunity. Women who do not have evidence of immunity should receive dose 1 of varicella vaccine upon completion or termination of pregnancy and before discharge from the healthcare facility. Dose 2 should be given 4–8 weeks after dose 1.

**4. Influenza vaccination.** Medical indications: chronic disorders of the cardiovascular or pulmonary systems, including asthma; chronic metabolic diseases, including diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications or by HIV); any condition (e.g., cognitive dysfunction, spinal cord injury, seizure disorder or other neuromuscular disorder) that compromises respiratory function or the handling of respiratory secretions or that can increase the risk of aspiration; and pregnancy during the influenza season. No data exist on the risk for secondary bacterial infections among persons with asplenia; however, influenza is a risk factor for secondary bacterial infections that can cause severe disease among persons with asplenia. Occupational indications: healthcare workers and employees of long-term care and assisted living facilities. Other indications: residents of nursing homes and other long-term care and assisted living facilities; persons likely to transmit influenza to persons at high risk (i.e., in-home household contacts and caregivers of children birth through 23 months of age, or persons of all ages with high-risk conditions); and anyone who wishes to be vaccinated.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION

## Footnotes

# Recommended Adult Immunization Schedule, UNITED STATES, OCTOBER 2005–SEPTEMBER 2006

For healthy nonpregnant persons aged 5–49 years without high-risk conditions who are not contacts of severely immunocompromised persons in special care units, intranasally administered influenza vaccine (Flumist®) may be administered in lieu of inactivated vaccine.

**5. Pneumococcal polysaccharide vaccination.** *Medical indications:* chronic disorders of the pulmonary system (excluding asthma); cardiovascular diseases; diabetes mellitus; chronic liver diseases, including liver disease as a result of alcohol abuse (e.g., cirrhosis); chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy [if elective splenectomy is planned, vaccinate at least 2 weeks before surgery]); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection [vaccinate as close to diagnosis as possible when CD4 cell counts are highest], leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids; and cochlear implants.

*Other indications:* Alaska Natives and certain American Indian populations; residents of nursing homes and other long-term care facilities.

**6. Revaccination with pneumococcal polysaccharide vaccine.** One-time revaccination after 5 years for persons with chronic renal failure or nephrotic syndrome; functional or anatomic asplenia (e.g., sickle cell disease or splenectomy); immunosuppressive conditions (e.g., congenital immunodeficiency, HIV infection, leukemia, lymphoma, multiple myeloma, Hodgkin disease, generalized malignancy, organ or bone marrow transplantation); or chemotherapy with alkylating agents, antimetabolites, or high-dose, long-term corticosteroids. For persons aged ≥65 years, one-time revaccination if they were vaccinated ≥5 years previously and were aged <65 years at the time of primary vaccination.

**7. Hepatitis A vaccination.** *Medical indications:* persons with clotting factor disorders or chronic liver disease. *Behavioral indications:* men who have sex with men or users of illegal drugs. *Occupational indications:* persons working with hepatitis A virus (HAV)-infected primates or with HAV in a research laboratory setting. *Other indications:* persons traveling to or working in countries that have high or intermediate endemicity of hepatitis A (for list of countries, visit [www.cdc.gov/travel/diseases.htm#hepa](http://www.cdc.gov/travel/diseases.htm#hepa)) as well as any person wishing to obtain immunity. Current vaccines should be given in a 2-dose series at either 0 and 6–12 months, or 0 and 6–18 months. If the combined hepatitis A and hepatitis B vaccine is used, administer 3 doses at 0, 1, and 6 months.

**8. Hepatitis B vaccination.** *Medical indications:* hemodialysis patients (use special formulation [40 µg/ml] or two 20-µg/ml doses) or patients who receive clotting factor concentrates. *Occupational indications:* healthcare workers and public-safety workers who have exposure to blood in the workplace; and persons in training in schools of medicine, dentistry, nursing, laboratory technology, and other allied health professions. *Behavioral indications:* injection-drug users; persons with more than one sex partner in the previous 6 months; persons with a recently acquired sexually transmitted disease (STD); and men who have sex with men. *Other indications:* household contacts and sex partners of persons with chronic hepatitis B virus (HBV) infection; clients and staff of institutions for the developmentally disabled; all clients of STD clinics; inmates of correctional facilities; or international travelers who will be in countries with high or intermediate prevalence of chronic HBV infection for >6 months (for list of countries, visit [www.cdc.gov/travel/diseases.htm#hepa](http://www.cdc.gov/travel/diseases.htm#hepa)).

**9. Meningococcal vaccination.** *Medical indications:* adults with anatomic or functional asplenia, or terminal complement component deficiencies. *Other indications:* first-year college students living in dormitories; microbiologists who are routinely exposed to isolates of *Moraxella meningitidis*; military recruits; and persons who travel to or reside in countries in which meningococcal disease is hyperendemic or epidemic (e.g., the “meningitis belt” of sub-Saharan Africa during the dry season [Dec–June]), particularly if contact with the local populations will be prolonged. Vaccination is required by the government of Saudi Arabia for all travelers to Mecca during the annual Hajj. Meningococcal conjugate vaccine is preferred for adults meeting any of the above indications who are aged ≤55 years, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Revaccination after 5 years may be indicated for adults previously vaccinated with MPSV4 who remain at high risk for infection (e.g., persons residing in areas in which disease is epidemic).

**10. Selected conditions for which *Haemophilus influenzae type b* (Hib) vaccine may be used.** *Haemophilus influenzae type b conjugate vaccines are licensed for children aged 6 weeks–71 months. No efficacy data are available on which to base a recommendation concerning use of Hib vaccine for older children and adults with the chronic conditions associated with an increased risk for Hib disease. However, studies suggest good immunogenicity in patients who have sickle cell disease, leukemia, or HIV infection, or have had splenectomies; administering vaccine to these patients is not contraindicated.*

**South Dakota Department of Health - Infectious Disease Surveillance  
Selected Morbidity Report, 1 January – 30 April 2006 (provisional)**

	Disease	2005 year-to-date	5-year median	Percent change
<b>Vaccine-Preventable Diseases</b>	Diphtheria	0	0	na
	Tetanus	0	0	na
	Pertussis	5	4	+25%
	Poliomyelitis	0	0	na
	Measles	0	0	na
	Mumps (to 6-2-06, confirmed/probable)	137	0	na
	Rubella	0	0	na
<b>Sexually Transmitted Infections and Blood-borne Diseases</b>	<i>Haemophilus influenza</i> type b	0	0	na
	HIV infection	12	8	+50%
	Hepatitis B	0	0	na
	Chlamydia	880	816	+8%
	Gonorrhea	112	84	+33%
	Genital Herpes	130	115	+13%
	Syphilis, primary & secondary	0	0	na
<b>Tuberculosis</b>	Tuberculosis	4	6	-33%
<b>Invasive Bacterial Diseases</b>	<i>Neisseria meningitidis</i>	2	1	+100%
	Invasive Group A <i>Streptococcus</i>	4	8	-50%
<b>Enteric Diseases</b>	<i>E. coli</i> O157:H7	1	2	-50%
	Campylobacteriosis	35	36	-3%
	Salmonellosis	26	26	+0%
	Shigellosis	19	8	+138%
	Giardiasis	20	26	-23%
	Cryptosporidiosis	10	9	+11%
<b>Vector-borne Diseases</b>	Hepatitis A	5	1	+400%
	Animal Rabies	17	31	-45%
	Tularemia	0	0	na
	Rocky Mountain Spotted Fever	0	0	na
	Malaria (imported)	1	0	na
	Hantavirus Pulmonary Syndrome	0	0	na
	Lyme disease	0	0	na
<b>Other Diseases</b>	West Nile Virus disease	0	0	na
	<i>Streptococcus pneumoniae</i> , drug-resistant	0	1	-100%
	Legionellosis	1	0	na
Additionally, the following diseases were reported: Chicken pox (28); Group B Strep, Invasive (4); Hepatitis C, chronic (10); Listeria (2); MRSA, Invasive (12).				

Communicable diseases are obligatorily reportable by physicians, hospitals, laboratories, and institutions.

The **Reportable Diseases List** is found at [www.state.sd.us/doh/Disease/report.htm](http://www.state.sd.us/doh/Disease/report.htm) or upon request.

Diseases are reportable by telephone, mail, fax, website or courier.

**Telephones:** 24 hour answering device 1-800-592-1804; for a live person at any time call 1-800-592-1861; after hours emergency 605-280-4810. **Fax** 605-773-5509.

Mail in a sealed envelope addressed to the DOH, Office of Disease Prevention, 615 E. 4th Street, Pierre, SD 57501, marked "Confidential Medical Report". **Secure website:** [www.state.sd.us/doh/diseasereport.htm](http://www.state.sd.us/doh/diseasereport.htm).

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**PUBLIC HEALTH BULLETIN**

State of South Dakota  
Department of Health  
600 E. Capitol Ave.  
Pierre, South Dakota 57501-2536

Return Service Requested

**TOLL FREE REPORTING NUMBER:**

1-800-592-1804

**COMMUNICABLE DISEASE HOTLINE:**

1-800-592-1861

**OFFICE OF  
DISEASE PREVENTION**  
605-773-3737

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